

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 14 December 2004

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In the Matter of:

BETTY E. BAILEY
Claimant

v.

CASE NO. 1998 BLA 00825

CONSOLIDATION COAL CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest
.....

DECISION AND ORDER ON REMAND

This proceeding is before me upon a second remand from the Benefits Review Board. On November 7, 2003, the Benefits Review Board (Board) issued a Decision and Order in this matter. The Board noted I awarded benefits on this survivor's claim in an initial Decision and Order issued on December 7, 1999. In that determination, I found the miner had worked 30 years in coal mine employment, the evidence established the presence of pneumoconiosis which arose out of coal mine employment and that the miner's death was due to pneumoconiosis. Employer appealed. In a Decision and Order issued on January 31, 2001, the Board found I erred in mechanically crediting the opinion of the miner's treating physicians without explaining how the examinations assisted those physicians in rendering their respective diagnoses of pneumoconiosis. The Board noted Drs. Fino and Castle had superior qualifications and the Board also found I erred in failing to explain why the treating physicians opinions were persuasive regarding the issue of the cause of the miner's death. On remand, in a Decision and Order issued October 16, 2002, I again found the persuasive chest x-ray and the medical opinion evidence sufficient to establish the presence of pneumoconiosis. In addition, I found the persuasive evidence sufficient to establish the presence of complicated pneumoconiosis so the irrebuttable presumption of death due to pneumoconiosis was applicable. I found, however, that the miner died from a respiratory death, so that his interstitial lung disease, which I found was pneumoconiosis, also played a substantial and significant role in his death. I concluded the

miner's lung disease and resultant treatment were contributing factors in his death. Therefore, I again awarded benefits on the widow's claim.

The Employer again appealed and, as noted, the Board issued its second determination on November 7, 2003. The Board found that I failed to specifically weigh and discuss together all the chest x-ray reports, CT scan reports and medical opinion evidence in determining if the evidence establishes the existence of complicated pneumoconiosis. The Board stated I should fully explain my credibility determinations and weighing of all relevant evidence, evaluate and discuss the respective qualifications of the medical doctors, and examine all medical reports of record and fully explain which physicians' reports are better supported by their underlying documentation. The Board noted that I listed the chest x-ray reports, but failed to include a clear discussion of the basis for how conflicts were resolved and I failed to discuss the qualifications of the readers. The Board also found my discussion of the CT scans unclear and may have been impacted by my inadequate assessment of the chest x-ray evidence. Finally, the Board found that contrary to my findings, Dr. Castle's opinion was based on more than the 1987 chest x-ray readings so my rejection of Dr. Castle's opinion was vacated. The Board also stated my findings that Dr. Fino's opinions were inconsistent with the Act were not demonstrated. The Board found it was proper to credit Dr. Khokar as the miner's treating physician, but since my reconsideration of the medical opinion evidence may impact the treatment of the opinions of the miner's treating physicians, Drs. Khokar and Hatahet, the Board remanded for further consideration of the evidence. The Board stated I must consider and weigh all relevant evidence to see if simple pneumoconiosis is established and likewise, I must weight all medical opinion evidence relevant to the cause of death to determine if death due to pneumoconiosis is established.

Initially, in this survivor's claim for benefits, filed on May 12, 1997 a threshold determination as to the existence of pneumoconiosis under § 718.202(a) must be made prior to considering whether the miner's death was due to disease under § 718.205 (2000)¹. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993). Pneumoconiosis may be established under Section 718.202(a) by chest x-ray, biopsy or autopsy, presumption or a medical opinion report.

The chest x-ray reports included in the record have been described in previous determinations in the miner's claim in the determinations by Administrative Law Judge Clement J. Kitchuk on June 27, 1989 and August 14, 1991 and the previous determinations on the widow's claim by the undersigned on December 7, 1999 and October 16, 2002 and those descriptions are incorporated by reference herein. All the physicians agreed the miner's x-ray films showed changes. The physicians disagreed, however, as to whether the changes demonstrated the presence of pneumoconiosis or some other pulmonary condition.

Physicians who read the earlier x-ray films all found evidence of pneumoconiosis as noted in the determinations on the miner's claim. These positive readings included readings by Drs. Aycoth, a board certified radiologist and B-reader and Dr. Gaziano, a B-reader. These films were re-read by Dr. Wheeler, a board certified radiologist and B-reader and Drs. Castle and Fino,

¹ The Department of Labor has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 20 C.F.R. Parts 718, 722, 725, and 726 (2002). In this case, filed in 1997, however, the previous 2000 regulations are applicable. All citations to the regulations, unless otherwise noted, refer to the 2000 regulations.

pulmonary specialists and B-readers. These physicians all concluded pneumoconiosis was not present, but some other pulmonary process was present. Dr. Wheeler concluded the changes present were due to tuberculosis. Dr. Castle concluded the changes present were due to granulomatous disease, probably sarcoidosis and Dr. Fino concluded the changes were due to a diffuse alveolar filling disease process.

The opinions of Drs. Wheeler, Castle, and Fino were similar on the more recent x-ray films taken from 1992 through the miner's death in April, 1997. In contrast, Dr. A. Dahhan, a pulmonary specialist and B-reader, read these x-ray films from 1992 through 1997 as showing evidence of pneumoconiosis, including finding rounded opacities, or shape "p".

On considering the x-ray reports, I find the positive readings are more persuasive. I note the high qualifications of Drs. Castle, Wheeler and Fino who consistently found the changes on the x-ray films were not pneumoconiosis. These physicians all identify another pulmonary disease as the cause of the changes present on the chest x-ray films. However, the hospital treatment records and the miner's treating physicians' records do not include any other findings to support these alternative diagnoses. In contrast, Dr. Dahhan's finding of pneumoconiosis is well supported by x-ray readings by physicians during the miner's hospitalization which noted the presence of pneumoconiosis. Although these hospital readings were not reported on the forms and in the manner set forth in the regulations, their consistent finding of pneumoconiosis lend strong support to Dr. Dahhan's positive readings, especially since these readings were obtained in the more objective setting of the miner's treatment rather than in response to the claim for benefits. In addition, Dr. Dahhan's conclusions are well supported and the contrary x-ray conclusions are challenged by Dr. Khokar, the miner's treating physician. Dr. Khokar noted that over his long history of treating the miner, there were no signs of tuberculosis, no history of tuberculosis and no reason to believe the opacities were due to granulomas. Specifically, Dr. Khokar noted there was no increase in white cells nor weight loss. In addition, Dr. Khokar stated the changes were not sarcoidosis since there were no other findings consistent with that disease, including enlarged lymph nodes, skin or eye lesions, or spleen enlargement. Thus, I find Dr. Dahhan's positive x-ray reports are well supported by the other evidence of record and the contrary negative reports of record are, therefore, outweighed. Accordingly, I find the positive x-ray reports by Dr. Dahhan as supported by the other evidence noted above, establish the presence of pneumoconiosis under the provisions of subsection 718.202(a)(1).

There is no biopsy or autopsy evidence, so the presence of pneumoconiosis is not established under subsection 718.202(a)(2).

In prior determinations, I found the evidence was sufficient to establish complicated pneumoconiosis. Dr. Rao, who read x-ray films during the miner's final hospitalization, reported pneumoconiosis with conglomerate densities. Apparently, based on those findings, Dr. Khokar listed complicated pneumoconiosis as one of the causes of death on the death certificate. In his deposition, Dr. Khokar stated he accepted the pre-existing diagnosis of complicated pneumoconiosis. Dr. Hatahet who examined the miner on a consultation in the hospital during his final days, reported the radiographic findings showed complicated pneumoconiosis. Dr. Hatahet stated he considered alternatives, including cancer, but the mass was stable and the miner was a non-smoker. It was less likely sarcoidosis since such a change was less likely with

the massive fibrosis in the upper lungs and this is not a type presentation for sarcoidosis. Thus, considering all the factors together, Dr. Hatahet concluded the masses or conglomeration present were due to pneumoconiosis and were complicated pneumoconiosis.

In contrast, Dr. Wheeler favored a finding that the conglomerate masses present were conglomerate tuberculosis after his review of chest x-rays and CT scan reports. He agreed the stability of the mass made cancer an unlikely possibility. Dr. Wheeler stated, however, that histoplasmosis was also a possibility. He stated he was sure the treating physicians were aware of the presence of the conglomerate masses of tuberculosis since it was so obvious on the chest x-ray. He also stated it was more statistically likely to be a mass of tuberculosis or histoplasmosis. Dr. Fino stated it was his opinion the change and progression seen on the chest x-rays and CT scans were due to a diffuse alveolar filling disease or sarcoidosis. He based his opinion on his finding that simple coal worker's pneumoconiosis was not present since there were no rounded opacities. In addition, Dr. Fino noted the masses were in the bases of the miner's lungs which is consistent with sarcoidosis and not coal worker's pneumoconiosis. Dr. Fino noted a possible smoking history. Dr. Castle also noted a smoking history which he stated was significant based on the hospital record of December, 1996. He concluded the miner did not have complicated coal worker's pneumoconiosis since the miner did not have simple coal worker's pneumoconiosis, or small rounded opacities. In addition, he stated the enlarged lymph nodes seen on chest x-ray are consistent with sarcoidosis.

Initially, I note that the reference in the hospital records relied upon by Dr. Castle to find the miner had a significant smoking history is a one sentence statement that the miner has "smoked in the past". The hospital record also notes the history was mainly obtained from the miner's wife and children. There is no indication of when in the past the miner smoked, nor any history of how long or how much he smoked. This one sentence is in contrast to the rest of the records where the miner consistently informed physicians he was a non-smoker. On review of the record, I find it more likely that this one sentence in the hospital report which did not include any details was in error in contrast to the rest of the record. While Dr. Castle credited this statement as establishing a significant smoking history over the miner's statements to examining physicians, Dr. Castle did not discuss the lack of any details in this statement. I find Dr. Castle's reliance upon this unsubstantiated and vague statement renders his opinion that the miner had a significant smoking history and, thus, his opinions on the miner's pulmonary condition less reliable. Dr. Fino cites a "possibility of smoking" in his report.

In addition, upon review of the various records, while noting the physicians all agree the x-ray films and CT scans show changes in the miner's lungs including masses or conglomeration, I note that Drs. Castle, Fino and Wheeler all based their opinion that complicated pneumoconiosis was not present in large part upon their conclusion that pneumoconiosis was not present. As discussed above under subsection 718.202(a)(1) and as will be discussed below under subsection 718.202(a)(4), however, I find the persuasive x-ray and medical opinion evidence establishes the presence of pneumoconiosis. Therefore, I accord less weight to the opinions of Drs. Castle, Fino and Wheeler regarding the presence of complicated pneumoconiosis. I do note, however, that Dr. Dahhan, a pulmonary specialist who agreed simple coal worker's pneumoconiosis was present found complicated pneumoconiosis was not present based on the CT scan results. The original CT scan reports are not in the record. The only CT

scan reports of record are those of Drs. Wheeler, Fino and Castle all of whom agreed complicated pneumoconiosis was not present. In contrast to these findings, Drs. Khokar and Hatahet, the miner's treating physicians during his final hospitalization, diagnosed complicated pneumoconiosis based on the previous diagnosis and the x-ray readings obtained during hospitalization. Upon consideration of all of this evidence, I find it is equally balanced. While the opinions of Drs. Wheeler, Fino and Castle are suspect since they failed to find the presence of simple coal worker's pneumoconiosis, likewise, the opinions that complicated coal worker's pneumoconiosis is present are based upon previous diagnoses. Upon reconsideration of the evidence relevant to the issue of complicated pneumoconiosis, therefore, I find it neither establishes the presence of complicated pneumoconiosis nor establishes that complicated pneumoconiosis is not present. Since the burden of proof is on the Claimant, however, I find Claimant has not established the presence of pneumoconiosis through the presumption at Section 718.304. furthermore, the presumptions at Section 718.305 and 718.306 are not applicable to this claim. Therefore, Claimant has not established pneumoconiosis by presumption under subsection 718.202(a)(3).

The final method for establishing pneumoconiosis is by medical opinion evidence under subsection 718.202(a)(4). In the prior determination, I accorded greater weight to Dr. Khokar's opinion as treating physician. The Board found this was proper since I explained the basis for this included the relationship Dr. Khokar had with the miner, the fact the four years he treated the miner were the four years prior to the miner's death, the frequency of his examination and treatment of the miner both in his office and during hospitalizations, and the extent of his treatment of the miner.

On further consideration of the other medical opinion reports of record, I note again the examining physicians, Drs. Vasudevan, Abernathy, Qazi, Khokar, Krishnan, and Hatahet all diagnosed pneumoconiosis. One other examining physician, Dr. Sherer, concluded the miner had advanced obstructive lung disease. In addition, review reports by Drs. Morgan and Fino on the miner's claim concluded coal worker's pneumoconiosis was present. More recently, Dr. Gaziano and Dr. Dahhan agreed coal worker's pneumoconiosis was present on review of the evidence on the widow's claim. In contrast, Drs. Fino and Castle both concluded coal worker's pneumoconiosis was not present upon review of the evidence in the widow's claim.

Upon consideration of the reports of Drs. Fino and Castle, however, I accord less weight to their conclusions for several reasons. I note that these physicians are highly qualified as pulmonary specialists, however, in this particular case, I find their conclusions are not as persuasive and the contrary reports of record. As noted above, Dr. Castle stated he placed high significance on one sentence in the December, 1996 hospital record that stated the miner had smoked in the past. I find Dr. Castle's opinion not well supported to the extent he relies upon this one non-specific statement which is contradicted by the rest of the record. In addition, Dr. Castle's opinion is based in large part on his findings on the chest x-ray films which are outweighed by the positive readings of record. Dr. Castle agrees that the miner had significant changes in his lungs and in his pulmonary function, however, he attributed these to sarcoidosis. There is no support in the treatment records or in the miner's final hospital records to support this diagnosis. I find Dr. Khokar's testimony regarding the absence of other symptoms of sarcoidosis persuasive. Thus, I accord greater weight to Dr. Khokar's finding that the changes

were due to coal dust exposure and pneumoconiosis and not to sarcoidosis. I also note Dr. Castle based his opinion in part on the absence of rales, crackles or crepitations on physical examination, while Dr. Khokar relied upon his on-going examinations and treatment which did document on-going shortness of breath. In this respect, I find no basis for crediting Dr. Castle's analysis of the findings on physical examination more than those of the examining physician as to whether they were or were not consistent with the diagnosis of pneumoconiosis.

Dr. Khokar's diagnosis of pneumoconiosis is well supported by the weight of the chest x-ray evidence, the review reports of Drs. Morgan, Gaziano and Dahhan. In addition, as noted, it is well supported and well based on his experience over a four year period as the miner's treating physician.

Dr. Fino's more recent reviews of the medical evidence is also based in small part on his statement that the miner may have had a smoking history. It is also based on his readings of x-ray reports and resultant conclusion that the changes present were not due to pneumoconiosis. These conclusions, however, are outweighed by the more credible x-ray readings of pneumoconiosis. Similar to the discussion above, I find the conclusions of Dr. Fino that the miner had some other pulmonary process are not well supported by the treatment records. While Dr. Castle noted he would have suggested a biopsy, and while such information would have, undoubtedly been helpful to a determination in this matter, such evidence is not present in this case. Under the circumstances of this case, where pneumoconiosis was established in earlier proceedings, where x-ray evidence of pneumoconiosis is more persuasive both in the earlier readings and in the more recent readings, where the treating physician diagnoses pneumoconiosis and where the treatment records provide no support for the alternative diagnoses posited by Drs. Fino and Castle, I find the probative weight of the medical opinion evidence, especially the reports of Dr. Khokar, the miner's treating physician, sufficient to establish the presence of pneumoconiosis under subsection 718.202(a)(4).

When considering all the evidence together, I find the persuasive positive chest x-ray films, the medical opinion reports of pneumoconiosis and the treatment records outweigh the contrary reports of Drs. Fino and Castle. Once again, while I note their high qualifications as pulmonary specialists and the fact they base their opinions on the readings of the CT scans as well as the chest x-ray films, I find they are weakened by their reliance upon questionable facts regarding the miner's smoking history, the fact their alternative diagnoses are not supported by the treatment records and the fact that the record includes equally probative chest x-ray reports of pneumoconiosis. I recognize the negative CT scan readings by Drs. Wheeler, Castle and Fino do support a finding of no pneumoconiosis, however, in this case, based on the other evidence, I find they are not sufficient to outweigh the contrary evidence of record, especially since the original CT scan readings were not included in the file, but the treating physicians and hospital records all continue to diagnose pneumoconiosis. In addition, I note these physicians do not agree on an alternative diagnosis, but posit three separate possibilities. That difference among them also lends support to the consistent findings of pneumoconiosis by the treating and examining physicians as supported by the review report of Dr. Dahhan.

Thus, upon re-consideration of all of the medical evidence of record, I find the Claimant has established the miner had pneumoconiosis pursuant to Section 718.202. Since the miner

worked more than 30 years in coal mine employment, she is entitled to the rebuttable presumption that the pneumoconiosis was caused by the miner's coal mine employment. Section 718.203. There is no medical opinion that diagnoses pneumoconiosis that attributes it to any other cause. For reasons similar to those set forth above, the findings of Drs. Castle, Fino and Wheeler that the miner's pulmonary changes are not due to pneumoconiosis but to other pulmonary causes are outweighed by the other more reliable, persuasive and probative evidence of record. Accordingly, I find Claimant has established her husband's pneumoconiosis arose out of coal mine employment.

The final issue to be resolved is whether the evidence is sufficient to establish the pneumoconiosis caused the miner's death. As noted, death due to pneumoconiosis can be established under Section 718.205(c) where the evidence establishes death due to pneumoconiosis, where the evidence establishes pneumoconiosis was a substantially contributing cause or factor leading to the miners death, or where the presumption set forth at Section 718.304 is applicable. In the prior determination, I found the irrebuttable presumption at Section 718.304 applicable to this case. Upon reconsideration, however, I find the evidence evenly balanced regarding the presence of complicated pneumoconiosis. Therefore, I find death due to pneumoconiosis is not established under subsection 718.205(c)(3).

In addition, the physicians all agree the miner died due to pneumonia, so death due to pneumoconiosis is not established under subsection 718.205(c)(1). I find, however, that death due to pneumoconiosis is established under subsection 718.205(c)(2) since the persuasive evidence establishes that pneumoconiosis was a substantially contributing cause of the miner's death.

Dr. Hatahet stated the miner's death was clearly related to the pre-existing coal worker's pneumoconiosis since the miner had very little functional lung tissue and the terminal illness including pneumonia and pulmonary emboli obliterated the useable lung function. Similarly, Dr. Khokar found the miner's underlying chronic lung disease was a precipitating or contributing factor in the miner's death. He noted the miner's pneumonia is a common cause of death in end stage respiratory disease. In addition, Dr. Fino agreed the miner's underlying chronic lung disease caused an impairment and contributed to his death. Although Dr. Fino concluded that disease was not pneumoconiosis, his findings on the relationship of that disease to the miner's death support the statements of Drs. Hatahet and Khokar.

Dr. Dahhan concluded the miner had pneumoconiosis but it did not cause his death since simple coal worker's pneumoconiosis does not cause pneumonia or pulmonary emboli. Dr. Dahhan did not discuss, however, whether or not the diagnosed pneumoconiosis contributed to the miner's weakened pulmonary state and contributed to the susceptibility of the miner to develop pneumonia as suggested by Dr. Hatahet. Dr. Dahhan's opinion, therefore, is not sufficient to contradict a finding that pneumoconiosis contributed to the miner's death. Dr. Castle concluded that even if pneumoconiosis were present it did not contribute to the miner's death since it would be sub-radiographic pneumoconiosis. This is based, however, on Dr. Castle's finding that the significant changes present in the miner's lungs were not pneumoconiosis, a finding which is outweighed by the other more persuasive evidence of record.

Therefore, Dr. Castle's opinion is not sufficient to outweigh the finding that the miner's pneumoconiosis contributed to his death.

I find, therefore, the opinions of Drs. Khokar and Hatahet are sufficient to establish that the miner's pneumoconiosis contributed to his death or was a factor leading to his death. Accordingly, I find Claimant has established the miner's death was due to pneumoconiosis pursuant to Section 718.205(c)(2). Accordingly, for all the foregoing reasons, the order awarding benefits shall be reinstated.

ORDER

IT IS ORDERED that the Employer, Consolidation Coal Company shall:

1. Pay to Betty Bailey, widow of Thomas Bailey, all benefits to which she is entitled under the Act commencing as of May 1, 1997, subject to offset for payments previously made to her by the Black Lung Trust Fund; and,
2. Reimburse the Trust Fund for the interim payments made to the Claimant.

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STUART A. LEVIN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C. 20210.